Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 03/15/01?
   b. The request was received on 03/05/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
   a. TWCC-60 and Letter Requesting Dispute Resolution dated 04/22/02
   b. HCFA-1450s
   c. EOBs
   d. Reimbursement data
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC-60 and Response to a Request for Dispute Resolution dated 05/08/02
   b. Medical Records
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/26/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 04/29/02. The response from the insurance carrier was received in the Division on 05/08/02. Based on 133.307 (i) the insurance carrier's response is timely

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: letter dated 04/11/02
   "The date of service involved in this dispute was from March 15, 2001 for treatment regarding the above-referenced claimant's work-related injury. The Carrier did not provide any payment exception codes to deny or reduce payment on the Explanation of Benefits, as required by the TWCC Rules and Commission instructions."

2. Respondent: letter dated 05/08/02
"The fees and services charged were properly reduced and no additional reimbursement is due. Provider has failed to justify any additional charges over and above what was reimbursed at a fair and reasonable rate."

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only date of service (DOS) eligible for review is 03/15/01.

2. The provider, an ambulatory surgery center, billed a total of $13,515.46 on the DOS in dispute.

3. The carrier reimbursed a total of $9,190.51 for the DOS in dispute.

4. Per the TWCC-60 the provider is requesting additional reimbursement of $4,157.21. The difference between the total billed amount and the total amount reimbursed is $4,324.21.

5. Based on the Reconsideration Request Form dated 01/08/02 which states, "(Provider) charges are fair and reasonable and the carrier's response dated 05/08/02 the issue of this dispute is what represents fair and reasonable reimbursement.

V. RATIONALE

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The carrier's response does not have a methodology that meets the requirements of Commission Rule 133.304 (i)(1-4).

The provider has submitted reimbursement data. In an effort to show inconsistent application by the carrier of its methodology and inconsistent reimbursement, the provider has submitted several EOBs, which indicate the carrier's medical audit company has reimbursed the provider from 64% to 80% of the billed charges on other patients. To date the carrier has reimbursed 68% of the billed charges on this dispute. The billed amount on these EOBs range from $1,330.79 (low) to $22,669.76 (high), the ICD-9 codes on these EOBs indicate the services rendered varied. The provider has submitted several EOBs from other carriers, these EOBs do show a higher percentage of the billed amount reimbursed and have the same ICD-9 code as the date of service

in dispute. In addition, the provider has submitted a reimbursement log that show reimbursements received from other carriers and self pay. This list shows the date of service, the amount billed, amount reimbursed, percentage of the billed amount reimbursed, and the payer of the bill. The list shows a wide range in the amount billed and in the amount of reimbursement received as a percentage. The list contains no references to the treatments/services performed and no ICD-9 codes.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The carrier has not submitted reimbursement data to explain how it arrived at what it considers fair and reasonable reimbursement. The provider has submitted EOBs from this carrier to document inconsistent application by the carrier of its methodology and EOBs from other carriers to document fair and reasonable reimbursement. Regardless of the lack of methodology in the carrier's response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. An analysis of recent decisions of the State Office of Administrative Hearings indicate minimal weight should be given to EOBs for documenting fair and reasonable reimbursement. The willingness of some carriers to reimburse at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(d) of the Texas Labor Code. The EOBs provide no evidence of amounts paid on behalf of managed care patients of ASCs or on behalf of other non-workers' compensation patients with an equivalent standard of living. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 18th day of June, 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.